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Redefining urological history taking – anal intercourse as the cause of unexplained symptoms in heterosexuals

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ABSTRACT

INTRODUCTION Symptoms suggestive of genito-urinary infection are frequent reasons for visits to general practitioners and account for approximately 15% of referrals to out-patient urology. The symptoms may be non-specific, and patients can undergo multiple investigations in an attempt to identify a cause.

PATIENTS AND METHODS We have seen several such patients, all of whom had engaged in unprotected heterosexual anal intercourse prior to the onset of their symptoms. Presenting complaints included urethral discomfort, acute epididymitis resistant to standard antibiotics, and sudden onset of overactive bladder symptoms.

RESULTS These patients illustrate the importance of careful history taking. Whilst some questions may be difficult to ask, they may reveal precipitating factors that the patient will be reluctant to volunteer. The repetitive nature of the behaviour may explain the chronicity of symptoms experienced by the patients, and avoidance of this activity may be the only management needed to improve them. For those with infective symptoms, the clinician's choice of antibiotic can be altered to provide anaerobic cover.

CONCLUSIONS A history of anal intercourse should be sought in patients with unexplained genito-urinary symptoms.

KEYWORDS

Anal sex – Urethritis – Urinary tract infection

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Symptoms suggestive of urological infection are very frequent reasons for visits to general practitioners and account for approximately 15% of referrals to out-patient urological services.[1] The symptoms such as urethral discomfort, urinary frequency, pelvic pain, and dysuria are non-specific; thus understandably, patients may undergo multiple investigations in an often futile attempt to identify a cause, leading to frustration for both doctor and patient alike. It is known that sexually active homosexual men are at increased risk of acute urinary tract infection, and *Escherichia coli* may contribute to non-gonococcal urethritis in this group.[2] Heterosexuals who engage in anal intercourse may be exposed to a similar risk.

We present here a number of patients, all of whom had engaged in unprotected heterosexual anal intercourse prior to the onset of their symptoms. The symptoms in many cases had been chronic; the patients had undergone multiple unrewarding investigations; it was only when a history of anal intercourse was sought by direct questioning that the likely underlying cause became apparent.

Patients and Methods

Case 1

A 29-year-old man presented with left-sided testicular pain and swelling with dysuria. A clinical diagnosis of epididymitis was made. He was investigated with testicular ultrasound and MSU, and treated with oral ciprofloxacin. At review, he admitted to unprotected anal intercourse with his partner prior to the onset of symptoms.

Case 2

A 43-year-old man who presented with urethral discomfort, and was noted to have an inflamed urethral meatus. He was investigated with a urinary tract ultrasound, uroflowmetry and mid-stream urine speimen (MSU) for culture. On

questioning, his symptoms dated back to his engagement in unprotected anal intercourse some months earlier, and so he was treated with oral ciprofloxacin and metronidazole.

Case 3

A 33-year-old man who presented with urethritis and bilateral testicular pain radiating to his inner thighs. He had participated in unprotected anal intercourse 1 week prior to the onset of these symptoms. He was investigated with an MSU and treated with oral ciprofloxacin and metronidazole

Case 4

A 35-year-old man who presented with overactive bladder symptoms. History taking revealed that he was a regular participant in unprotected anal intercourse with his wife. He was investigated with a *Chlamydia* spp. culture, urine cytology, flexible cystoscopy, ultrasound, plain X-ray of KUB (kidneys, ureter and bladder), and urinary flow rate. He was advised to use a condom during anal intercourse, and his symptoms resolved with life-style changes.

Case 5

A 27-year-old man who presented with urethral discomfort, testicular and lower backache. He was investigated with an MSU, uroflowmetry and a urinary ultrasound scan, all of which were normal. The clinical impression was one of low-grade infection related to his unprotected anal intercourse which he had later admitted to. He was treated with ciprofloxacin and metronidazole, with advice to use a condom during anal intercourse.

Case 6

A 27-year-old woman presented with recurrent cystitis and pelvic pain. There was global tenderness on vaginal examination, and she admitted to anal intercourse on occasion. She was investigated with an MSU, urinary ultrasound scan and KUB. She was treated with prophylactic antibiotics and advised to desist from anal intercourse.

Case 7

A 39-year-old man presented to the emergency department systemically unwell with epididymo-orchitis. He was treated with gentamicin and oral ciprofloxacin but his condition failed to improve over the next few days. The history was taken again, and at this time he was directly questioned about, and admitted to, unprotected anal intercourse. He was then commenced on combination therapy with metronidazole, after which there was clinical improvement.

Case 8

A 35-year-old man presented to out-patients with perineal discomfort. He was initially investigated with urinary ultrasound, MSU and semen cultures, the latter of which grew coliforms on two occasions. He was questioned about anal intercourse, and admitted that he had participated in this once with a previous girlfriend. His symptoms resolved and semen cultures at this time were clear. At his follow-up out-patient visit, it transpired that his previous girlfriend was Muslim and that no vaginal intercourse had ever taken place – she had only permitted anal intercourse during their relationship in order to retain purity.

Case 9

A 38-year-old man presented to out-patients with a classical history of two urinary tract infections with no history of stone disease or lower urinary tract symptoms. On direct questioning, he admitted that unprotected anal intercourse had preceded the first infection. He was investigated with ultrasound, KUB and flow rate, all of which were normal, and advised to use a condom when engaging in anal intercourse in the future.

Discussion

These cases illustrate the importance of careful history taking in urological patients. The sexual history needs to include direct questions about the nature of sexual activity undertaken by an individual regardless of the sexual orientation of the patient. Whilst some questions may be felt to be too embarrassing or intrusive to pose, they may reveal precipitating factors that the patient will be reluctant to volunteer. Anal intercourse, whether homosexual or heterosexual, is considered taboo by many individuals, including some who engage in it. Notably, none of the patients in our series volunteered the information.

Anal intercourse amongst heterosexuals is common in young people,[3] being practised by 24.5% of men and 22.9% of women in the age group 25–34 years in the UK,[4] and is often unprotected. It is more common in young women with a non-intact family structure and lower parental education,[5] but is certainly not confined to this group; indeed, 7 of the 8 patients in this series were private patients. The presentation of heterosexual anal intercourse as more socially acceptable than in the past is exemplified by its appearance and discussion in mainstream culture in the 'Bridget Jones' films. In some cultures, the practice of vaginal intercourse outside marriage remains forbidden leading perhaps to an increase in the practice of anal intercourse to retain purity. The repetitive nature of the behaviour may explain the chronicity of symptoms experienced by the patients, and avoidance of this activity may be the only management needed to resolve the symptoms. For those with infective symptoms, the clinician's choice of antibiotic can be altered to provide anaerobic cover in addition to more traditional urinary tract pathogens. This is illustrated in Case 7, where

the patient's clinical state and inflammatory markers only began to improve when metronidazole was commenced. The use of condoms in those who practice anal intercourse is clearly advisable.

Conclusions

A history of anal intercourse should be sought in patients with unexplained urological symptoms, regardless of whether the patient is heterosexual or homosexual.

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